INSURANCE VERIFICATION

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook updates Department of Veterans Affairs (VA) procedures for providing information regarding insurance verification in VHA health care facilities.

2. SUMMARY OF CHANGES. This VHA Handbook updates current procedures for insurance verification.

3. RELATED ISSUES. VHA Handbooks 1601A.01 through 1601E.01.

4. RESPONSIBLE OFFICE. The Chief Business Office (16) is the responsible for the contents of this VHA Handbook. Questions may be addressed to 202-254-0406.

5. RESCISSION. VHA Directive 2003-055 is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of August 2011.

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CONTENTS

INSURANCE VERIFICATION

PARAGRAPH **PAGE**

1. Purpose 1

2. Authority 1

3. Background 1

4. Scope 1

5. Authority for the Department of Veterans Affairs (VA) to Recover the Costs of Care 1

6. Protected Health Information (PHI) 2

7. General Information Required for Protected Health Information 2

8. Definitions 4

INSURANCE VERIFICATION

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides information on the mandated procedures for verifying insurance information with third-party payers.

2. AUTHORITY

a. Title 38 United States Code (U.S.C.), Section 1729 authorizes the Department of Veterans Affairs (VA) to recover or collect for care or services, reasonable charges as determined by the Secretary, from a third-party to the extent that the veteran, or the provider of the care or services, would be eligible to receive payment for care or services from the third-party if the care or services had not been furnished by a department or agency of the United States (U.S.).

3. BACKGROUND

a. Insurance verification is vital to the success of the VA revenue collection process because accurate information is needed to effectively bill and collect claims from third-party payers for services to veterans. It is important to contact the third-party payer and verify the veteran's specific policy coverage before submitting claims.

b. VA Health Care Facilities (HCFs) must use the Pre-registration Program process to update the veteran's complete address, home and work telephone numbers, insurance information, next of kin, emergency contact, and employer information.

4. SCOPE

a. All VHA personnel verifying insurance provide third-party payers with only the minimum amount of appropriate Protected Health Information (PHI) necessary to verify insurance, and said personnel request only the minimum amount of information necessary from third-party payers in order to effectively bill and collect for services to veterans.

b. This VHA Handbook provides details on the authority for VA to recover costs of care and PHI.

5. AUTHORITY FOR THE DEPARTMENT OF VETERANS AFFAIRS (VA) TO RECOVER THE COSTS OF CARE

Title 38 U.S.C. §1729 requires third-party payers to pay VA reasonable charges for certain medical care and services. This authority is the basis for the need for VHA to verify insurance coverage in order to receive payment from third-party payers for VHA medical care and services rendered to veterans.

6. PROTECTED HEALTH INFORMATION (PHI)

a. With implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), new requirements for insurance verification were impacted for the registration and insurance verification process. This Handbook outlines the appropriate information to request from a health plan when verifying insurance and what information may be required from VA facilities before giving out PHI.

b. This Handbook describes the minimum necessary information required by health plans to be assured that VHA has a legitimate right to the PHI being requested, as required by HIPAA. VHA personnel verifying this information must possess a certain amount of information prior to contacting a health plan for verification. Health plans may refuse to provide information to VHA personnel if the minimum necessary information for insurance verification is not provided to the plan. The required information may vary by health plan, and may be negotiated if the health plan requires additional data then that what is outlined in this Handbook.

NOTE: *For more information on PHI, see Public Law (Pub. L.) 104-191 and 45 Code of Federal Regulations (CFR) Part 164.*

7. GENERAL INFORMATION REQUIRED FOR PROTECTED HEALTH INFORMATION

a. VHA personnel, prior to contacting third-party payers, must have at the least the following:

(1) VA medical center Tax Identification (ID) number,

(2) Facility ID number (VA specific),

(3) Name of patient,

(4) Social Security Number (SSN)

(5) Date of birth,

(6) Policy holder or subscriber's name,

(7) Policy or subscriber's number, and

(8) Group number and/or group name.

b. If the spouse is the policy holder or subscriber, the following additional information must be obtained:

(1) Spouse's name,

(2) Spouse's date of birth,

(3) Group name and number (if known),

(4) Spouse's SSN, and

(5) Primary or secondary insurance.

c. VHA personnel identifying the insurance must have obtained from the insurance company the:

(1) Effective date of policy,

(2) Policy type,

(3) Filing timeframe,

(4) Coverage and/or benefits, and

(5) Mailing address for claims.

d. VHA personnel may capture other information during insurance verification with the health plans. This additional information may be instrumental when submitting claims for reimbursement. This information may only be captured if applicable to the treatment or payment of a specified claim. VHA personnel should only ask for information that is applicable to the treatment of the patient and which satisfies the minimum necessary requirements outlined in the regulations resulting from HIPAA. This includes the:

(1) Effective Date, to include the:

(a) Pre-existing timeframe, and

(b) Expiration date (if applicable).

(2) Policy type, and filing timeframe.

(3) Group name and number.

(4) Inpatient and Outpatient coverage, to include:

(a) Deductible and/or co-payment amounts,

(b) Reimbursement percentage,

(c) Out-of-pocket or stop loss (dollar amount),

(d) Lifetime maximum, and

(e) Pre-certification requirement.

(5) Skilled nursing facility, to include:

(a) Pre-Admissions Requirement,

(b) Reimbursement Percentage,

(c) Daily or Dollar Maximums, and

(d) Pre-certification requirement.

(6) Prescription health, to include the:

(a) Medical or prescription network,

(b) Name and address of the network administering the prescription,

(c) Reimbursement percentage,

(d) Deductible and/or co-payment amounts,

(e) Maximum limitations, and

(f) Pre-certification requirement.

(7) Dental, to include the:

(a) Deductible and/or co-payment amounts,

(b) Level of benefits,

(c) Reimbursement percentage,

(d) Maximum limitations, and

(e) Pre-certification requirement.

(8) Mental Health (MH) inpatient and/or outpatient, to include the MH:

(a) Medical or network,

(b) Network name and address,

(c) Reimbursement percentage,

(d) Deductible and/or co-payment amounts,

(c) Maximum limitations, and

(d) Pre-certification requirement.

(9) Home Health, to include the:

(a) Reimbursement percentage,

(b) Maximum limitations, and

(c) Pre-certification requirement.

(10) Vision, to include the vision:

(a) Medical or network,

(b) Network name and address,

(c) Reimbursement percentage,

(d) Deductible and/or co-payment amounts,

(e) Frequency of visits, and

(f) Pre-certification requirement.

(11) Hospice, Rehabilitation, and Intravenous (IV) Management, to include the:

(a) Lifetime maximum,

(b) Maximum number of days, and

(c) Pre-certification requirement.

8. DEFINITIONS

a. **Anniversary Date.** The anniversary date is date on which cardholders or groups will be re-enrolled each year subsequent to their initial enrollment; and it is the date which begins the "contract year."

b. **Benefit Package.** The benefit package includes all the services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services.

c. **Benefit Period.** The benefit period is the period of time for which benefits are payable under an insurance contract.

d. **Birthday Rule.** The birthday rule is the guideline for the designation of the primary insurance policy when dependents are concurrently enrolled in two or more policies.

e. **Carrier.** The carrier is the insurance company; the insurer.

f. **Coinsurance.** Coinsurance is the specified percentage of the cost of services the patient must pay the health care provider.

g. **Coordination of Benefits (COB).** COB is a clause written in an insurance policy, or stipulated by state law, that requires insurance companies to coordinate the reimbursement of benefits when a policyholder has two or more medical insurance policies. ***NOTE:*** *The benefits from the combined policies may pay up to, but may not exceed, 100 percent of the covered benefits of the combined policies for all medical expenses submitted.*

h. **Copayment (Copays).** A copayment is money owed VA by certain veterans for services rendered. VA requires copays, such as Means Test, Geographic Means Test (GMT) copays, Long-term Care (LTC) copays, and Medication copays, for certain priorities of veterans. VA copays are not related to insurance.

i. **Cost Sharing.** Cost sharing means that the provisions of a health insurance policy require the insured, or otherwise covered individual, to pay some portion of covered medical expenses. Forms of cost sharing are deductibles, coinsurance, and copayments. ***NOTE:*** *This definition is associated with cost sharing for TRICARE.*

j. **Coverage.** The coverage is the extent of benefits provided under a health care policy.

k. **Covered Person.** A "covered person" is any person entitled to health care benefits under an insurance policy.

l. **Deductible.** The deductible is the specified amount of annual out-of-pocket expense for covered medical services that the insured must incur and pay each policy year to a health care provider before the insurance company will pay benefits.

m. **Defense Enrollment Eligibility Reporting System (DEERS).** DEERS is the government's computerized database listing all active duty and retired military sponsors and their dependents. DEERS is used to verify eligibility for TRICARE benefits.

n. **Dependent.** A dependent is a person who, by virtue of the financial support provided by the policyholder, meets the legal requirements for inclusion in a policy or program.

o. **Dual Coverage.** Dual coverage refers to the fact that the beneficiary has coverage under more than one health insurance policy.

p. **Effective Date.** The effective date is the date on which insurance coverage begins.

q. **Exclusions.** Exclusions refer to disorders, diseases, or treatments listed as uncovered services (not reimbursable) in an insurance policy.

r. **Family Deductible.** Family deductible refers to the deductible provision that limits the maximum deductible amount required for all covered persons under family coverage.

s. **Group Name and Number.** The group name and number is the name and numerical identification assigned to a specific group of insured patients.

t. **Health Care.** The performance of diagnostic, therapeutic, and preventive services and procedures by health care providers to persons who are sick, injured, or concerned about their health status.

u. **Health Insurance.** Health insurance is a contract between the policyholder and an insurance carrier or government program to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care rendered by health care professionals.

v. **Identification (ID) Card.** The ID card is the card issued by the plan to the subscriber as evidence of membership and coverage. The card shows the subscriber's name, number, type of coverage, and effective date.

w. **Identification (ID) Number.** The ID number is the policy number or contract number, many times the cardholder's Social Security number (SSN).

x. **Indemnity Plan (income protection).** An indemnity plan refers to a regular commercial fee-for-service insurance program designed to protect against the loss of income resulting from a disability and/or major illness.

y. **Insurance.** Insurance is protection against risk, loss, or ruin by a contract in which an insurer or underwriter guarantees in return for the payment of a premium to pay a sum of money to the insured in the event of some contingency, such as death, accident, or illness.

z. **Insurance Carrier.** The insurance carrier is the insurance company (insurer) that sells the policies and administers the contract.

aa. **Insured.** The insured is the policyholder; the subscriber; the person who contracts with an insurance company for insurance coverage.

bb. **Lifetime Maximum.** The lifetime maximum is the maximum amount that a major medical plan will pay toward a subscriber's claims in a lifetime.

cc. **Maximum Benefits.** The maximum benefits refers to the highest amount the insurance company will pay for medical claims during a specified period, either set on a yearly basis or for the lifetime of the policy.

dd. **Member.** A member is the individual (employee or dependent) enrolled under a Managed Care Program.

ee. **Participating Physician or Provider.** The participating physician or provider is a health care provider who has entered into a contract with the government, or an insurance company, to provide medical services to enrolled subscribers at a negotiated fee.

ff. **Plan.** Plan is a term that refers to the types of coverage offered by an insurance company.

gg. **Policy.** The policy is the legal document issued by a company to the policyholder that outlines the conditions and terms of the insurance, also called a policy contract or contract.

hh. **Policyholder.** The party that applies for, and is issued, an insurance policy.

ii. **Pre-Existing Condition.** A pre-existing condition is a medical condition(s) under active treatment at the time the application is made for an insurance policy.

jj. **Primary Carrier.** the primary carrier is the insurance carrier that has first responsibility under COB.

kk. **Subscriber.** the subscriber is the insured; the insurance policyholder.

ll. **Termination Date.** The date on which insurance coverage ends.

mm. **Third-Party Payer.** The third-party payer is an individual or corporation that makes a payment on an obligation or debt that is not a party to the contract that created the obligation or debt.

nn. **Verification.** Verification is the process performed to verify and interpret the patient's insurance coverage and benefit levels.